

# Program Integrity

## Office of Medicaid Policy Planning

The Indiana Family and Social Services Administration  
Indiana Health Coverage Programs  
2019



# Disclaimer

Only formal responses to questions asked through the [www.in.gov/fssa](http://www.in.gov/fssa) inquiry process will be considered official and valid by the State. No participant shall rely upon, take any action, or make any decision based upon any verbal communication with any State employee including responses in today's presentation.

## Official Points of Contact

[program.integrity@fssa.in.gov](mailto:program.integrity@fssa.in.gov)

1-800-457-4515 Option 8

[www.indianamedicaid.com](http://www.indianamedicaid.com)



# Agenda

## Program Integrity

- Auditing
- Voluntary Self Disclosure
- Investigations & Coordination
- Prepayment Review
- Estate Recovery
- Contact Information



# Program Integrity (PI)

## Fraud Waste and Abuse

Provider Fraud: Misrepresentation with the intent to illegally obtain services, payments or other gains

Provider Abuse: Any action that is inconsistent with generally accepted practices (both clinically and from a business standpoint) which results in an incorrect payment for services rendered

### Reporting Provider Fraud, Waste, and Abuse:

- Call: 1-800-457-4515
- Email: [Program.Integrity@Fssa.IN.gov](mailto:Program.Integrity@Fssa.IN.gov)



# Audit and Self Disclosures

1-800-457-4515

[Programintegrity.Sur@fssa.in.gov](mailto:Programintegrity.Sur@fssa.in.gov)



## Program Integrity (PI) Audits

- Retrospective review of provider billing compliance
- Audit Approach
  - Algorithms: Focuses on a specific issue that is reflected in billing of multiple providers
  - Provider Specific: Looking for various areas of concern within all of a single provider's billing
- Can utilize statistically-valid, random-sampling & extrapolation
- Recovery of overpayments
  - Providers have up to 300 days from date of identification to pay back
  - IHCP has up to 365 days from date of identification to repay the Federal share back



## Audit Process

1. Preliminary review of provider billing, payment, and audit history
2. Request of medical records from provider (if applicable)
3. On-site or in-house medical record audit
4. *Draft Audit Findings* (DAF) letter of preliminary audit results
5. Request for administrative reconsideration (optional)
6. *Final Calculation of Overpayment* (FCO) letter or *Final Audit Findings* (FAF) letter
7. Administrative appeal process (optional)
8. Recoupment of overpayment (if applicable)



## Example 1

Provider A billed Medicaid for E/M code CPT 99201 (new patient code) for an established patient seen by the same provider within the last 3 years.

### Outcome:

State recouped the different amount between what was reimbursed for CPT 99201 and CPT 99211 (established patient code) which should have been billed instead.

## Example 2

The state arrived at Provider C's office for an onsite audit of medical records for specific set of claims. The state found that Provider C never documented any of the services billed by the provider.

### Outcome:

All reimbursement for claims without medical record documentation present was recouped.

## Example 3

Provider B was found to be billing modifier 59 on every claim in order to bypass the claim system edits in order to receive extra reimbursement for two or more non-distinct services on same date of service and lacked the documentation to support that they were performed separately.

### Outcome:

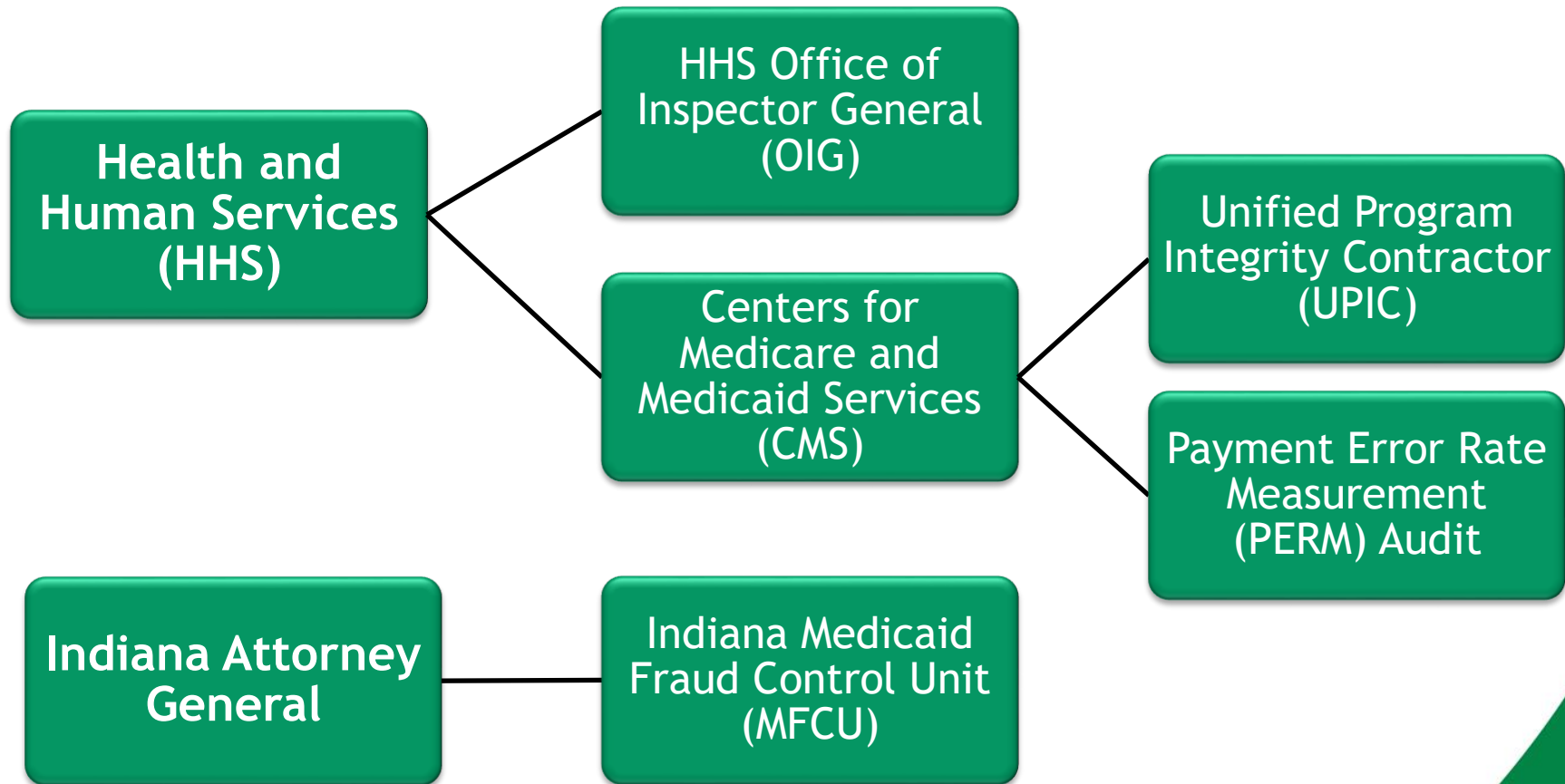
State paid the first service rendered that was medically necessary and had documentation, but recouped the rest of the services on that same date of service.

The provider's billing practice was discussed with the PI Investigations & Coordination team regarding a possible referral to the IN Medicaid Fraud Control Unit (MFCU).





## Other Auditing Entities



## Payment Error Rate Measurement (PERM)

- Measures improper payments in Medicaid and CHIP and produces error rates for each program.
- The error rates are based on reviews of the fee-for-service (FFS) and managed care claims.
- Review for data processing, medical record issues, and/or eligibility.
- Final report outlining:
  - Amount of erroneous payments
  - Recovery amounts of erroneous payments
  - Causes of errors and actions taken to correct them
  - Target for future payment rates



## PERM Review Year 2021

- Claims from July 1, 2019 - June 30, 2020
- Providers selected may be required to provide medical documentation to federal contractors
- Ensure provider enrollment and contact information is up-to-date
- Further information via banners and webinars on this topic
- Email: [ProgramIntegrity.SUR@fssa.in.gov](mailto:ProgramIntegrity.SUR@fssa.in.gov)



# Voluntary Self-Disclosure

Voluntary Self-Disclosure is a protocol for providers wishing to report fee-for-service overpayments they have identified

IHCP ask that Providers use the protocol to report the following items:

- Provider billing system errors or issues that result in overpayments
- Potential violations of federal, state, or local laws
- Potential violations of regulations
- Potential fraud
- Potential violations of billing, coding, or other healthcare policies
- Specific compliance issues
- Cumulative amounts greater than \$1,000

Protocol and Self-Disclosure packet may be found at:

<https://www.in.gov/medicaid/providers/656.htm>



# Voluntary Self-Disclosures

(continued)

## **Benefit of Voluntary Self-Disclosure**

- Results in a better outcome for the provider
- Provider will be in compliance with the law
- Interest will not be assessed on the disclosed overpayment

## **Statistically-valid Random Sampling and Extrapolation**

- Submit an explanation of the extrapolation process was utilized and how the overpayments were discovered

**A provider cannot use their Medicare error rate on their Indiana Medicaid claim population**



# Investigations & Coordination

## Including reporting Provider Fraud, Waste, and Abuse

1-800-457-4515

[ProgramIntegrity.fssa@fssa.in.gov](mailto:ProgramIntegrity.fssa@fssa.in.gov)



# Investigations & Coordination

## The Role of Investigations & Coordination

- Responds to complaints from many sources
- Conduct preliminary investigations to establish a **Credible Allegation of Fraud (CAF)**
- Makes referrals to and collaborates with **MFCU** on provider investigations
- Coordinate with FSSA operating divisions (DDRS, DA, DMHA, DFR)
- Oversee the Managed Care Entities (MCE's) to monitor their Special Investigation Units (SIU) and referrals of provider fraud allegations



# Investigations & Coordination

(continued)

## Prepayment Review

- Providers placed on prepayment review as part of PI's fulfillment of CMS' surveillance and utilization control program mandate
- Provider submits supporting documentation with every claim
- Claims will suspend for review prior to payment
- The Provider must meet **85%** accuracy rate in claims submission for three (3) consecutive months within the initial six (6) month review period
- The Provider's claim volume must stay within 10% of the claim volume prior to Prepayment Review





# Investigations & Coordination

(continued)

## Example 1

A member calls the concern line to report that they suspect that their dentist billed Medicaid for an exam and a cleaning they did not render to them.

### Outcome:

The State checks the claims data and determines that the provider did not bill Medicaid for the disputed services. The State closes the matter without taking any further action.

## Example 3

A member calls the concern line to report that they suspect that their home health provider billed for home health services that they did not render to them.

### Outcome:

The State performs a preliminary investigation on the provider and finds that a credible allegation of fraud exists. The State refers the case to the MFCU and requests that the provider be placed on payment suspension.

## Example 2

An employee of a mental health clinic calls the concern line to report that the clinic that they work for is upcoding a time based behavioral health code.

### Outcome:

The State performs a preliminary investigation on the provider (which includes performing a limited documentation review and a provider peer comparison) and substantiates the allegation. The State performs an audit of the provider's usage of the time based behavioral health code.



# Estate Recovery

1-877-267-0013

[EstateRecovery@fssa.in.gov](mailto:EstateRecovery@fssa.in.gov)

<https://www.in.gov/fssa/dfr/4874.htm>



# Estate Recovery

## What is Estate Recovery?

1965 - Medicaid signed into law. Congress gives states the option to recover costs for care for individuals age 65 and over. Some states pass estate recovery laws.

1982 - TEFRA (Tax Equity & Fiscal Responsibility Act) - first federal estate recovery law; not mandatory so many states still didn't pass their own estate recovery laws however, states did lose certain federal funding for failing to do so

1993 - OBRA (Omnibus Budget Reconstruction Act) - mandated recovery for all states for individuals age 55 and over



# Estate Recovery

(continued)

## What Expenses Can Be Recovered by Medicaid?

- Medical expenses paid on behalf of an individuals age 55 and over
- Medical expenses paid on behalf of an individual under age 55 who was a resident of a Long Term Care facility and who was not reasonably expected to return home



# Estate Recovery

(continued)

## Are There Exceptions to Estate Recovery?

- Real and personal property when necessary for the support of a surviving spouse, a dependent child or a dependent who is non-supporting due to blindness or disability
- Personal effects, ornaments, keepsakes
- Assets of any recipient who purchased a qualified Long Term Care policy
- When there is a minor child, no recovery is made while the child is under 21 or who is blind or disabled



# Estate Recovery

(continued)

## What Can Be Paid From an Estate Before Paying Medicaid?

- If no prepaid funeral, can exempt \$2,150 for funeral and burial expenses.
- Debts & taxes having preference under US law
- Debts & taxes having preference under Indiana law
- Nothing else can be paid prior to satisfying Medicaid



## What About Hardships or Exceptional Circumstances?

- Undue Hardship Waivers may be granted if pursuing the Medicaid claim would result in:
  - causing a beneficiary becoming eligible for public assistance
  - causing a beneficiary to remain dependent on public assistance
  - loss of income producing assets where there is no other income and income does not exceed 100% of poverty level
  - other compelling circumstances
- Undue Hardship determined on a case-by-case basis
- Only immediate family may qualify (spouse, child, grandchild, great-grandchild, parent, grandparent, sibling)
  - Others might qualify in exceptional circumstances with good cause shown

# IHCP LIVE

Webinar presentations both links to upcoming live webinars, and recordings of past webinars

<https://www.in.gov/medicaid/providers/1014.htm>





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# Session Survey - Tuesday

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.



<https://tinyurl.com/fssa1068>



# Session Survey - Thursday

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<https://tinyurl.com/fssa1078>

